TRANSITION

1.0. CONTRACT TRANSITION-IN

1.1. Start-Up Plan

This comprehensive plan shall be submitted electronically, in MS Project files, to the Contracting Officer (CO) and the Contracting Officer Representative (COR) no later than ten calendar days following contract award. A separate plan shall be submitted for each region being transitioned, within 15 calendar days from the start of the transition period for each region. The plans shall address all events and milestones that need to occur for each functional area described in this contract to enable the start of service performance under this contract. Within 15 calendar days following the interface meetings, the incoming contractor shall submit to TMA a revised start-up plan for approval which incorporates the results of the Transition Specifications and Interface meetings. The final start-up plan will be incorporated into the contract at no cost to the Government.

1.2. Transitions Specifications Meetings

The contractor shall attend a two to four day meeting with TMA at the TMA office in Aurora, CO, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule for phase-in and phase-out activities. TMA will notify the contractor as to the exact date of the meeting. The initial transition specification meeting may include a meeting with the incoming and outgoing Managed Care Support contractors for the first region to be transitioned. Contractor representatives attending this meeting shall have the experience, expertise, and authority to provide approvals and establish project commitments on behalf of their organization.

Separate two day meetings shall be held, at the TMA office in Aurora, CO, with the outgoing and the incoming Managed Care Support contractor for each region and TMA at the start of the transition period for the region. A schedule for these meetings will be established during the initial transition specifications meeting.

1.3. Interface Meetings

Within 30 calendar days from contract award, the contractor shall arrange meetings with Government and external agencies to establish all systems interfaces necessary to meet the requirements of this contract, including, but not limited to the Defense Eligibility Enrollment System, Medicare Carriers and Fiscal Intermediaries, *MHS* Information Assurance Certification and Accreditation Team, Managed Care Support or Health Care Service Contractors and their subcontractor(s) for claims processing, PDTS, PBMs*, and* TMA *Communications and Customer Service*. TMA representatives shall be included in these

meetings and all plans developed shall be submitted to the TMA Contracting Officer (CO) and the Contracting Officer Representative (COR) within 10 calendar days after the meeting.

2.0. START-UP REQUIREMENTS

2.1. Systems Development

Approximately 60 calendar days prior to the initiation of services delivery under this contract, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by the TMA or its designees, to include a demonstration by the contractor of the system(s) capabilities, to determine whether the systems satisfy the requirements of TRICARE as otherwise provided in the contract. This includes the telecommunications links with TMA, DEERS and PDTS. All systems and telecommunications necessary to perform benchmarking testing must be operational at the start of benchmark testing, as outlined in paragraph 3.0. The review will also confirm that the hardware, software, and communications links required for operating the automated TRICARE Duplicate Claims System have been installed and are ready for TMA installation of the Duplicate Claims System application software (see Chapters 9 and 10). This review is in addition to Benchmark testing. The contractor shall effect any modifications required by TMA prior to the initiation of services delivery under this contract.

2.2. Medicare Crossover Claims

No later than 60 calendar days prior to the start of the service delivery in any region, the contractor shall have established contracts with all appropriate Medicare Carriers and Fiscal Intermediaries for receipt of TRICARE crossover claims for all dual eligible beneficiaries for implementation when the outgoing contractor terminates claims processing. No later than 60 days prior to the start of services delivery, the contractor shall demonstrate to TMA successful receipt and testing of electronic claims batches from each applicable Medicare Carrier and Fiscal intermediary and accurate processing of dual eligible claims, including claims for services covered by TRICARE but not covered by Medicare.

2.3. Execution Of Memoranda Of Understanding (MOU)

2.3.1. MOU With Managed Care Support Contractors

Sixty calendar days prior to the start of services delivery in any region, the contractor shall have executed Memoranda of Understanding with all TRICARE Managed Care Support Contractors. The MOU shall include, but not limited to provider file update coordination, beneficiary history transfers, customer service coordination and marketing/ education coordination. The contractor shall provide two copies of each executed MOU to the CO and the COR within 10 calendar days following the execution of the MOU.

2.4. Claims Processing System And Operations

During the period between the date of award and the start of services delivery, contractor shall, pursuant to an implementation schedule approved by TMA, meet the following requirements:

2.4.1. Contractor File Conversions And Testing

The contractor shall perform initial conversion and testing of all ADP files (e.g., provider files, pricing files, and beneficiary history and deductible files) not later than 30 calendar days following receipt of the files from the outgoing Managed Care Support and incoming Managed Care Support contractor(s). All ADP file conversions shall be fully tested and operational for the Benchmark (see paragraph 3.0.).

2.4.2. Receipt Of Outgoing Managed Care Support Contractor's Weekly Shipment Of History Updates And Dual Operations

2.4.2.1. Beginning with the 120th calendar day prior to the start of services delivery and continuing after the start of services delivery until all pertinent claims received by the outgoing contractor have been processed, the contractor shall convert the weekly shipments of the beneficiary history and deductible file updates from the outgoing contractor(s) within two work days following receipt. These files shall be validated by the contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two workdays following conversion. Following the start of services delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate deductibles.

2.4.2.2. During the period after the start of services delivery when the incoming TDEFIC processor and the outgoing Managed Care Support contractor are processing claims, both contractors shall maintain close interface on history update exchanges and provider file maintenance. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing.

2.4.3. Ongoing Receipt Of Managed Care Support Contractor's Shipment Of History Updates And Dual Operations

2.4.3.1. Beginning with the start of services delivery in any region, the contractor shall convert the weekly shipments of the beneficiary history and deductible file updates from the Managed Care Support contractor(s) within two work days following receipt. These files shall be validated by the contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two workdays following conversion. Following the start of services delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate deductibles.

2.4.3.2. After the start of services delivery, when the incoming TDEFIC processor and the Managed Care Support contractor are processing claims, both contractors shall maintain close interface on history update exchanges and provider file maintenance.

2.4.4. Phase-In Requirements Related to Transitional Cases

In notifying beneficiaries of the transition to another contractor, all contractors shall include instructions on how the beneficiary may obtain assistance with transitional

care. Costs related to each contract will be kept separate for purposes of contract accountability.

2.4.4.1. Inpatient Transitional Cases

2.4.4.1.1. Cases Transitioned From The Outgoing Managed Care Support Contractor

These are Medicare eligible beneficiaries that are inpatients (occupying an inpatient bed) at 0001 hours on the first day of the contract period in which the incoming TDEFIC contractor's delivery of services commences.

In the case of DRG reimbursement, the claim shall be processed by the outgoing MCSC through the first month following the start of health care delivery of the incoming TDEFIC contractor. The TDEFIC contractor thereafter is responsible for payment.

In the case of per diem reimbursement, the outgoing MCSC is responsible for payment of all the institutional charges accrued prior to 0001 hours on the first day of health care delivery of the incoming TDEFIC contractor. The TDEFIC contractor thereafter is responsible for payment.

2.4.4.1.2. Cases Transitioned From The Managed Care Support Contractor On An Ongoing Basis

These are beneficiaries that are inpatients (occupying an inpatient bed) at 0001 hours on the first day they become Medicare eligible.

In the case of DRG reimbursement, the outgoing MCSC shall forward all claims to the TDEFIC contractor within three business days of receipt of the claim. The TDEFIC contractor shall process all claims subject to DRG reimbursement under normal double coverage procedures.

In the case of per diem reimbursement, the outgoing MCSC is responsible for payment of all the institutional charges accrued prior to 0001 hours on the day the beneficiary becomes eligible for Medicare. The outgoing MCSC shall forward all claims for services rendered after the beneficiary becomes Medicare eligible to the TDEFIC contractor within three business days of receipt of the claim. The TDEFIC contractor shall process all claims for services rendered after the beneficiary becomes Medicare eligible according to normal double coverage procedures.

2.4.5. Non-Network Claims

The *outgoing* contractor shall *transfer all* non-network claims, *regardless of* dates of service, to the *TDEFIC claims processor*, that are received by the outgoing contractor *on or after the start of TDEFIC claims processing for the outgoing processor's region*, or as agreed to at the Transition meeting. These claims shall be forwarded to the incoming contractor by overnight delivery, within 48 hours of receipt.

2.4.6. Health Insurance Portability And Accountability Act (HIPAA)

The covered entity may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the compliance date (HHS Privacy Regulation §164.532).

2.4.7. Installation And Operation Of The Duplicate Claims System

The contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the Duplicate Claims System no later than 60 days prior to the start of the services delivery. See TOM, Chapters 9 and 10, for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to services delivery, TMA will provide and install the Duplicate Claims System application software on the contractor designated personal computers and provide on-site training for users of the Duplicate Claims System in accordance with Chapters 9 and 10. Following the start of services delivery, the Duplicate Claims System will begin displaying identified potential duplicate claim sets for which the contractor has responsibility. The contractor shall begin using the Duplicate Claims System to resolve potential duplicate claim sets in accordance with Chapters 9 and 10 and the transition plan requirements.

2.5. Contractor Weekly Status Reporting

The contractor shall submit a weekly status report of phase-in and operational activities and inventories to TMA beginning the 20th calendar day following "Notice of Award" by TMA through the 180th calendar day after the start of services delivery (or as directed by the Contracting Officer based on the status of the transition and other operational factors). A separate weekly status report will be submitted for each region being transitioned. The status report will address only those items identified as being key to the success of the transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

2.6. Public Notification Program - Provider And Congressional Mailing

The contractor shall prepare a mailing to all network and non-network TRICARE providers and Congressional offices within the region being transitioned by the 45th calendar day prior to the start of services delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the CO and the COR for review, and the TMA Communications and Customer Service Directorate for approval not later than 90 calendar days prior to the start of each service delivery period. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

3.0. INSTRUCTIONS FOR BENCHMARK TESTING

3.1. General

3.1.1. Prior to the start of services delivery, the contractor shall demonstrate the ability of its staff and its automated eligibility checking, and claims processing systems to accurately

process TRICARE claims in accordance with current requirements, including receipt and processing of Medicare cross-over claims. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by *the contractor under the oversight of* TMA and must be completed no later than 60 days prior to the start of services delivery under this contract. *Due to the realignment and staggered implementation of the TRICARE regions, the Government reserves the right to benchmark each part of the region as it is phased-in.*

3.1.2. Additionally, prior to the start of services delivery in any region, the contractor shall demonstrate its ability to receive and accurately process crossover claims from Medicare for the region being transitioned.

3.1.3. A benchmark *shall* consist of up to 1,000 claims, testing a multitude of claim conditions, including TRICARE covered and non-covered services, certified and non-certified providers, eligible and non-eligible beneficiaries. This benchmark may require up to 17 consecutive calendar days at the contractor's site.

3.1.4. A benchmark test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. All aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, access control, etc.

3.1.5. The contractor shall demonstrate its ability to conduct eligibility checking, and claims processing functions to include: claims control and development, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost share files on the CDCF, accessing and updating PDTS for pharmacy claims, submitting and modifying provider and pricing records, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions (EOBs, summary vouchers, payment records, checks, and management reports). Clerical functions will be evaluated including correctly coding diagnoses, medical and surgical procedures and accurately resolving edit exceptions. The benchmark test may include testing of any and all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the benchmark will test generation and acceptance of TRICARE Encounter Data (TED) records for every test claim. Contractor compliance with applicable Health Insurance Portability and Accountability Act of 1996 requirements and all applicable security requirements will be included in benchmark tests as appropriate.

3.1.6. Contractors shall *conduct the* benchmark test. The test will be comprised of *both* paper *and* electronic *claims* and must include at least one test batch of claims from each applicable Medicare carrier or FI claims processor for the region being transitioned. The contractor *shall* be required to create test claims*, including referrals and authorizations* from test scenarios *provided* to the *incoming contractor by TMA*. *The contractor shall supplement these test scenarios with any internal conditions they feel appropriate for testing to ensure a minimum of 1,000*

claims are tested. Under certain circumstances, however, this number may be reduced at the discretion of the Contracting Officer.

3.1.7. A benchmark test of a current contractor's system may be administered at any time by TMA upon instructions by the Contracting Officer. All contractor costs incurred to comply with the performance of the Benchmark test are the responsibility of the contractor.

3.2. Conducting The Benchmark

3.2.1. *At t*he *time of the scheduled benchmark test a TMA* Benchmark Team comprised of up to 12 people *will arrive at the contractor's work site to monitor the testing and assist the contractor in* the *evaluation* of the benchmark test *results*.

3.2.2. The amount of time a contractor *shall* have to process the benchmark test claims and provide all of the output (excluding TED) to the benchmark team for evaluation will vary depending on the scope of the benchmark and volume of claims being tested. As a guide, the following table is provided for contractor planning purposes.

NUMBER OF BENCHMARK CLAIMS/SCENARIOS	NUMBER OF DAYS TO COMPLETE PROCESSING
UP TO 100	1-2
UP TO 500	2-4
UP TO 1000	4-7

3.2.3. The contractor will be informed at the pre-benchmark meeting (see paragraph 3.3.1.) of the exact number of days to be allotted for processing the benchmark claims and test scenarios and providing all of the output (excluding TED) to the Benchmark Team for evaluation.

3.2.4. The benchmark team will provide answers to all contractors written and telephonic development questions *related to the test scenarios provided by TMA* and will evaluate the contractor's output against the benchmark test conditions.

3.2.5. The benchmark team will require a conference room that can be locked with table(s) large enough to accommodate up to 12 people. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

3.2.6. The contractor shall provide up-to-date copies of the TRICARE Operations Manual, TRICARE Systems Manual, Policy Manual and TRICARE Reimbursement Manual, a complete set of current ICD- 9-CM diagnostic coding manuals, the currently approved CPT-4 procedural coding manual, the most recent applicable drug pricing reference, in either hard copy or on-line, whichever is used by the contractor, explanations of the contractor's EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOBs, checks or summary vouchers.

3.2.7. The contractor shall provide an appropriate printer and a minimum of three computer terminals in the conference room with on-line access to all internal and external systems used to process the benchmark test claims to include, but not limited to: provider files (TEPRVs), pricing files (TEPRCs) (area prevailing and CHAMPUS Maximum Allowable

Charge pricing). DEERS; catastrophic cap and deductible files; and any other files used in processing claims. The contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

3.2.8. The contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the contractor's staff involved in performing the benchmark by function (e.g., data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams will be provided prior to the benchmark test.

3.3. Procedures

3.3.1. Approximately *6*0 calendar days *following award* to the *contractor*, representatives from TMA will meet with the contractor's staff to provide an overview of the benchmark test process, receive an overview of the claims processing system, collect data for use in the benchmark, and discuss the dates of the test and information regarding the administration of the benchmark test. *At this time, TMA shall provide the test scenarios to the contractor that are to be used in the development of their test claims.*

NOTE: At TMA's discretion, the test must be completed NLT 120 calendar days prior to the start of services delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the contractor's claims processing site. Data requirements will be coordinated at the pre-benchmark meeting to ensure that the contractor adequately prepares all files prior to the benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

3.3.2. On the first day of the benchmark test, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

3.3.3. During the Benchmark Test the contractor shall process the claims and provide TMA with all input documentation, including hardcopy printouts of electronic crossover files and all output, including EOBs, summary vouchers, suspense reports, checks, claims histories, etc. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output *is* required for electronic transactions.

3.3.4. The contractor shall provide output for evaluation *by TMA and contractor personnel* as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the benchmark team will be discussed with the contractor at the pre-benchmark meeting.

3.3.5. TMA *and contractor personnel* will *jointly* compare the *benchmark test claim* output against the benchmark test conditions for each claim processed during the test. All appropriate contractor and benchmark team personnel shall be present to answer any questions raised.

3.3.6. At the conclusion of the benchmark test, an exit conference *may* be held with the contractor staff to brief the contractor on all findings identified during the benchmark. The contractor shall correct all findings identified in the benchmark no later than 45 days from the date of the initial report. A draft report of the initial test results will be left with the

contractor for review. The initial Benchmark Test Report will be forwarded to the contractor by TMA within 45 calendar days of the last day of the test. For any claims processing errors assessed with which the contractor disagrees; a written description of the disagreement along with any specific references must be included with the claims.

3.3.7. Within seven calendar days of the last day of the benchmark test, the contractor shall prepare and submit the initial TRICARE Encounter Data (TED) submission to the TMA, Operations/Advanced Technology Integration Center (O/ATIC) for evaluation. The contractor shall be notified of any TED failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TED until 100% of the original benchmark test TED have passed the edits and are accepted by TMA.

3.3.8. The contractor has 45 calendar days from the date of the initial benchmark test report to submit the final corrected TED to TMA. New TED need not be generated to reflect changes created from claims processing corrections, however, all TED originally submitted for the benchmark test claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TED have been accepted by TMA.

3.4. Operational Aspects

3.4.1. The benchmark test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features proposed for the production system in the contractor's proposal. When the benchmark test is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TED from being generated and sent to TMA.

3.4.2. Certain external test systems and files (e.g., DEERS) are an integral component of the benchmark test and the contractor is expected to perform all necessary verifications, queries, etc., according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations Division, and the TMA ADP contractor to ensure that direct interface with any required external test Systems (i.e., DEERS) is established and operational prior to the benchmark test.

3.4.3. TED shall be generated from the benchmark test claims, including Medicare crossover claims, and provided to TMA for processing as scheduled at the pre-benchmark meeting. The contractor shall coordinate with the TMA, Operations/Advanced Technology Integration (O/ATIC), for TED submission procedures.

4.0. CONTRACT TRANSITION-OUT

4.1. Transitions Specifications Meeting

The outgoing contractor shall attend a meeting with representatives of the incoming contractor and TMA at the TMA office in Aurora, CO, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/ phase-in activities. TMA will notify the contractor as to the exact date of the meeting. The

outgoing contractor shall provide a proposed phase-out plan at the Transition Specifications Meeting.

4.2. Data

The outgoing contractor shall provide to TMA (or, at the option of TMA, to a successor contractor) such information as TMA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. Such information may include, but is not limited to, the following:

- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

4.3. Phase-Out Of The Contractor's Claims Processing Operations

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

4.3.1. Provide Information

The contractor shall, upon receipt of written request from TMA, provide to potential offerors such items and data as required by TMA. This shall include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

4.3.2. Transfer Of Electronic File Specifications

- The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, not later than three calendar days following award announcement, electronic copies of the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:
- The TRICARE Provider Files (TEPRVs)
- The TRICARE Pricing Files (TEPRCs)
- The Beneficiary History and Deductible Files (Including Eligibility Files, if applicable)
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; tax identification number; address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the

current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meets exemption criteria, as exempt from the inpatient mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

4.3.3. Transfer Of ADP Files (Electronic)

The outgoing contractor shall prepare in electronic format and transfer to the incoming contractor or TMA, by the 15th calendar day following the Transition Specifications meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files, such as the Provider and Pricing files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or TMA.

4.3.4. Outgoing Contractor Weekly Shipment Of History Updates

The outgoing contractor shall transfer to the incoming contractor, in electronic format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 120th calendar day prior to the start of services delivery (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule. See dual operations in paragraph 2.4.2.

4.3.5. Transfer Of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., Congressional and TMA completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and Chapter 2. The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center as required by Chapter 2. The contractor shall provide samples, formats and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

4.3.6. EOB Record Data Retention And Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the Contracting Officer's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to TMA. TMA shall be the final authority in determining the form and/or acceptability of the data and/or microcopies.

4.3.7. Outgoing Contractor Weekly Status Reporting

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to TMA beginning the 20th calendar day following the Specifications Meeting until otherwise notified by the

Contracting Officer to discontinue. This shall be done in accordance with specifications of the official transition schedule.

4.4. Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process to completion all claims, to include adjustments, *received* during its period of services delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's services delivery. All claims shall meet the same standards as outlined in the current contract.

- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.

- For transitional case requirements, refer to paragraph 2.4.4.1.

- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

- Complete all appeal/grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

4.4.1. Correction Of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all TED record edit errors not later than 210 calendar days following the start of the incoming contractor's services delivery.

4.4.2. Cost Accounting

If the outgoing contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability.

4.4.3. Records Disposition

The outgoing contractor shall comply with the provisions of Chapter 2, in final disposition of all files and documentation. The contractor shall include a records disposition plan as part of the phase-out plan submitted to TMA at the Transition Specifications Meeting.